NHS
Newcastle Gateshead
Clinical Commissioning Group

Primary Care Co-commissioning - Next Steps

1. Aim

The aim of this paper is to brief members and seek views on the next steps for primary care co-commissioning.

2. Background

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning aims to support the development of high quality integrated out-of-hospital services based around the needs of local people.

In November 2014, NHS England released 'Next steps towards primary care co-commissioning' offering CCGs the opportunity to take on additional responsibilities for the commissioning of primary care services. There were three levels that CCGs could assume from 1st April 2015:

- Level One: Greater CCG Involvement in NHS England decision making
- Level Two: Joint Decision Making (Joint Commissioning) by NHS England and CCGs
- Level Three: CCGs taking on delegated responsibilities from NHS England

Newcastle Gateshead CCG undertook a process by which member practices voted for their preferred option. The result of this vote was that the CCG would enter into Joint Decision Making with NHS England on 1st April 2015. Since then, the Joint Committee has been established and business is being conducted via that forum. A subsequent practice vote to move to level 3 was undertaken in October 2015. Member practices voted to remain at level 2.

The CCG Executive now seek to move to co-commissioning level 3 with a member practice vote by 20th September 2016 after a members meeting on 13th September. This will ensure sufficient time to engage member practices in the process.

3. Level 3 CCG Delegated Responsibilities

Under level 3 the role of the CCG will be to exercise the Delegated Functions which include;

- decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to:
    - Enhanced Services
    - Local Incentive Schemes including the design of such schemes
    - establishment of new GP practices, including branch surgeries and closure of GP practices

- the approval of practice mergers
- planning primary medical care services in the area, including carrying out needs assessments
- performance management of GP practices, including decisions and liaison with the CQC (but excluding decisions in relation to the performers list)
- management of the Delegated Funds
- Premises Costs Directions Functions (revenue)

Legally, NHS England retains the residual liability for the performance of primary medical care commissioning, including issuing contract breaches, as well as to exercise the Reserved Functions including;

- management of the performers list
- revalidation and appraisal process
- complaints management
- decisions regarding the Prime Minister's Challenge Fund
- Capital Expenditure Functions

4. Level 3 Benefits and Risks

Detailed SWOT from 2015 see Appendix 1.

Benefits for practices include;

- Enables CCGs to prioritise investment for acute, primary and community services
- Budget slippage will be retained for investment in primary care locally whereas at level 2 budget slippage is retained by NHSE to spend across the area or return as underspend
- Local knowledge and relationships;
    - support collaborative solutions to problems
    - enable more timely resolution of queries
- CCG roles and structures provide easier contact points and ongoing support for practices

Risks include;

- Any potential overspend and financial risks will be borne by the CCG
- Delegated functions are complex (see below), CCG skills and competencies will need to be developed
- The delegated functions mean that risks management will need to be enhanced.
- The CCG will be also responsible for delivering the CCG elements of the NHSE Assurance Process and CQC Process

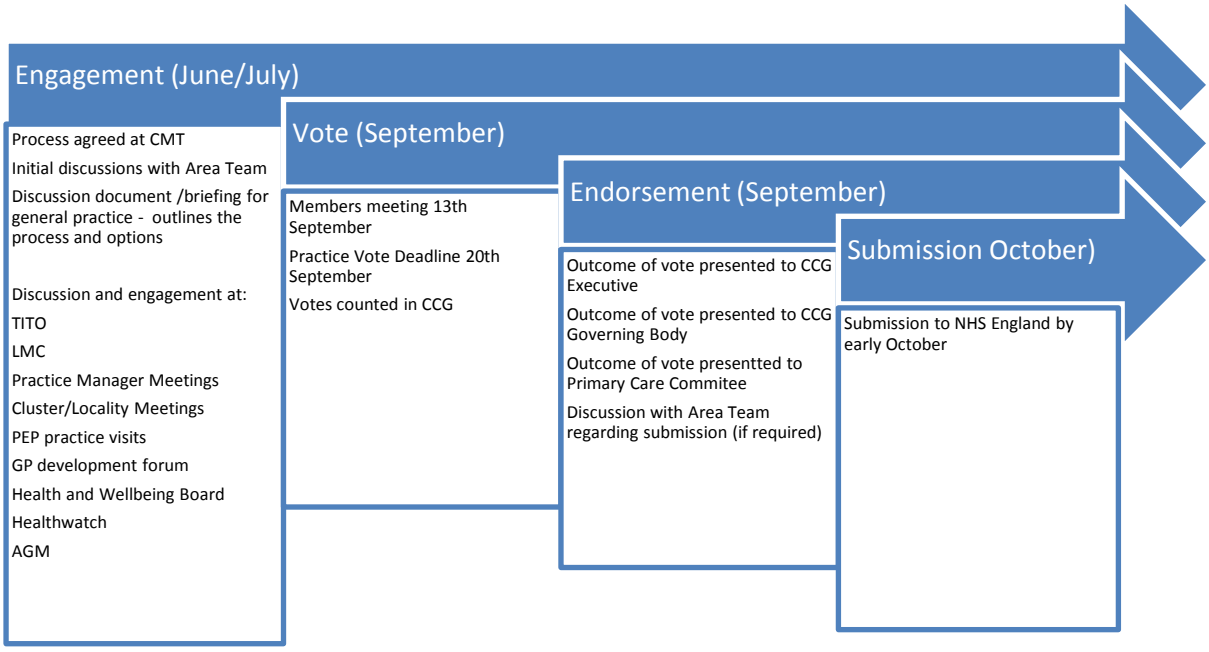
5. CCG process for decision making

In order to identify if a move to assume delegated responsibilities is supported by the member practices, it is proposed that a similar process be undertaken to the one used in 2014/15 and October 2015. Member practices will be invited to vote for their

preferred option for assuming commissioning responsibility for primary care. The vote will be operated as a one practice, one vote system. Member practices and the LMC will be engaged in the decision to move to level 3. The CCG will also engage Healthwatch in both Newcastle and Gateshead and the Health and Wellbeing boards in the process.

The Primary Care Commissioning Committee and Governing Body will endorse the decision of the CCG prior to submission. The timetable is very tight from the member vote in September to submission in early October (date awaited from NHSE) therefore the governance and ratification process could be problematic.

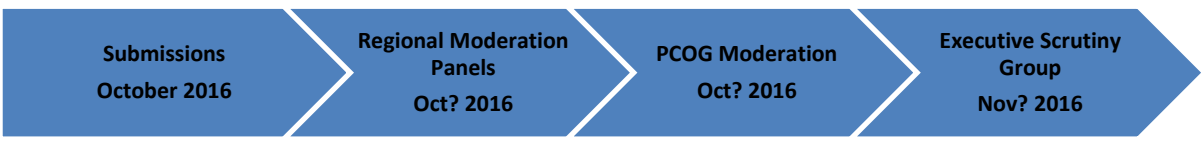
To ensure the CCG is ready to make a submission should the outcome of the vote be that the CCG pursues level 3 commissioning responsibility, the following timetable is proposed:



6. Delegated commissioning next steps

NHS England will publish the process for CCGs to apply to take on delegated arrangements in 2016/17 in due course. This is currently an annual process. It is anticipated that we will apply in October 2016 to take on responsibilities 1 April 2017.

A summary of the key points in the existing approvals process can be found below:



The process currently outlined by NHSE is as follows:

- Apply to take on delegated responsibility from 1 April 2017
- Template and supporting information available – date awaited
- Submission deadline **October 2016** (likely to be early in the month) (to england.co-commissioning@nhs.net and to their local NHS England team)
- Regions will support CCGs to ensure the submissions meet requirements
- Regional panels will review proposals and make recommendations to a national panel on which proposals to take forward
- Primary Care Oversight Group (PCOG) will provide national moderation date awaited.
- PCOG will make recommendations to an Executive Scrutiny Group - date awaited
- CCGs will be notified of the outcome.

7. Engagement

The level of member engagement is important as this could impact on the outcome of the member practice vote. Member engagement and communication is key to ensuring member practice support the move. For this reason it is proposed that the vote be undertaken in September. There will be a member practice meeting regarding co-commissioning on 13th September resulting in a vote by 20th September. The following engagement process is suggested;

8. Stakeholder perspective

a) Practices – anecdotal mixed feedback from practices
b) LMC – fully support the move to level 3 and would like to see practice engagement
c) Healthwatch – no known views at this time
d) Health and Wellbeing Boards - no known views at this time
e) Area Team – strongly support the move to level 3 however the move is not mandatory

Appendix 1. Local SWOT

In 2014/15 the CCG developed a SWOT analysis for each of the options for co-commissioning.

Level 2 - Continuing with joint commissioning arrangements

Strength	**Weakness**
• Reduced potential for challenge re conflict of interests (clearer 'blue water') • Pooled budget 'soft £' • Reduced reporting requirements • Current arrangements working well – split between transformational and transactional • Not a barrier to making progress in certain areas • Current Area Team – skills and experience	Reduces CCG motivation to enact significant change – e.g. more passive about larger opportunities
Opportunity	**Threat**
Increased flexibility to select priority areas for local area	Resources are taken to support model 3 CCGs Area team may not be able to pick up where they are required to No clear owner

Level 3 – Move to delegated commissioning

Strength	**Weakness**
• Greater control of existing e.g. premises/IT • 'hard wired £' • Greater control of transformation (alignment) • Aligns with national direction of travel therefore allows for greater alignment	• More transactional • CCG skills and experience will need development • Other local CCGs not made any significant changes yet. • CCG capacity to deliver
Opportunity	**Threat**
• Opportunity to mould QoF to meet local commissioning intentions • CCG embracing wider opportunities which may not be immediately obvious	• Greater opportunity for challenge re conflict of interest • Additional performance management responsibility • More change for general practice is destabilising • Capacity required to carry out performance management • Limited available capacity within the CCG to deliver • Potential impact on existing stakeholder relationships- requires additional relationship management • Needs increase pace of market development; Requires CCG to mobilise primary care